NOTICE OF A SPECIAL MEETING OF THE CALOPTIMA HEALTH BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE

THURSDAY, NOVEMBER 13, 2025
3:00 P.M.

505 CITY PARKWAY WEST, SUITE 108-N
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
José Mayorga, M.D., Chair
Maura Byron
Catherine Green

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL KENNADAY LEAVITT	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo	Sharon Dwiers

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(s) identifying the item(s) and submit to Clerk of the Board. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors' Quality Assurance Committee, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar, the reading of the individual agenda items, and/or the beginning of Public Comments. When addressing the Committee, it is requested that you state your name for the record. Address the Committee as a whole through the Chair. Comments to individual Committee Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

In compliance with the Americans with Disabilities Act, those requiring accommodations for this meeting should notify the Clerk of the Board's Office at (714) 246-8806, at least 72 hours prior to the meeting.

The Board of Directors' Quality Assurance Committee meeting agenda and supporting materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, 8 a.m. – 5:00 p.m., Monday-Friday, and online at www.caloptima.org. Committee meeting audio is streamed live on the CalOptima Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at: **https://us02web.zoom.us/webinar/register/WN_8r5ulXieSWO5fXBjAUrj_Q** and Join the Meeting.
Webinar ID: **810 5293 4500**
Passcode: **766599** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

ADVISORY COMMITTEE UPDATES
None.

PUBLIC COMMENTS
At this time, members of the public may address the Committee on matters not appearing on the agenda, but under the jurisdiction of the Board of Directors' Quality Assurance Committee. Speakers will be limited to three (3) minutes.

CONSENT CALENDAR
None.

REPORTS/DISCUSSION ITEMS
1. Recommend that the Board of Directors Approve the CalOptima Health Measurement Year 2026 Medi-Cal and OneCare Pay for Value Programs and Measurement Year 2027 Covered California Pay for Value Program

INFORMATION ITEMS
2. OneCare Stars Update

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee on November 13, 2025 at 3:00 p.m. (PST)

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 13, 2025
Special Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

1. Recommend that the Board of Directors Approve the CalOptima Health Measurement Year 2026 Medi-Cal and OneCare Pay for Value Programs and Measurement Year 2027 Covered California Pay for Value Program

Contact

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Actions

Recommend that the Board of Directors:

1. Approve CalOptima Health Measurement Year 2026 Medi-Cal Delegated Health Network Pay for Value Performance Program effective January 1, 2026, through December 31, 2026.
2. Approve CalOptima Health Measurement Year 2026 OneCare Delegated Health Network Pay for Value Performance Program effective January 1, 2026, through December 31, 2026.
3. Approve CalOptima Health Measurement Year 2027 Covered California Health Network Pay for Value Performance Program effective January 1, 2027, through December 31, 2027.
4. Approve Measurement Year 2026 Medi-Cal and OneCare Primary Care Provider Pay for Value Performance Programs, one-time provider incentives for digital technology improvements and utilization of physician incentive software to provide a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions.

Background

CalOptima Health's Pay for Value Performance Program (P4V Program) recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health Networks (HNs), CalOptima Health Community Network (CHCN), and HN's primary care physicians (PCPs), are eligible to participate in the P4V Program.

The purpose of CalOptima Health's P4V Program is to:

1. Recognize and reward HNs and CHCN PCPs for demonstrating quality performance;
2. Drive improvement in quality outcomes and processes through monetary incentives and penalties;
3. Provide comparative performance information for members, providers, and the public on CalOptima Health's HN and CHCN PCP performance; and
4. Provide industry benchmarks and data-driven feedback to HNs and CHCN PCPs on their quality improvement efforts.

CalOptima Health staff have obtained feedback from HN and CHCN physician partners on recommendations to refine and improve the P4V Program to drive improvement and achieve quality

Back to Agenda

goals. Feedback includes increasing incentive amounts, phasing-in programmatic changes, and shifting from a retrospective pay for performance model to a real-time, point-of-care approach that rewards physicians, and potentially physician staff, for the completion of specific value-based care actions. These recommendations are incorporated into the Calendar Year 2026 program elements discussed below.

Discussion

Measurement Process

CalOptima Health staff calculates the quality rating score for each HN annually. For Measurement Year (MY) 2026, staff will use the Integrated Healthcare Association (IHA) methodology for both Medi-Cal and OneCare. This will enable CalOptima Health to use an industry standard methodology and improve efficiencies by using one standard quality rating methodology. The performance score is derived from the most recently available audited Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Centers for Medicare & Medicaid Services (CMS) Star measure data. The Covered California P4V Program will be based on comparison to benchmarks only since prior year rates will not be available.

Medi-Cal Delegated Health Network P4V Program

Staff recommends implementing MY 2026 Delegated Health Network Medi-Cal P4V Program with the following program components:

1. Maintain IHA pay for performance methodology to assess performance.
    - The methodology uses both attainment and improvement to assess performance and is based on the CMS hospital value-based purchasing model.
    - The greater of either the attainment or improvement score will be used to calculate incentive payments.
    - A total quality score will be calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum.
        - The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned. For example, a quality rating of 3.5 equates to 35% of the incentive allocation.

2. Utilize the MY 2026 Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures held to minimum performance level (MPL) for the HEDIS measurement set. Based on preliminary notice from DHCS, the MY 2026 Medi-Cal P4V Program will have a total of 20 quality measures. CalOptima Health's P4V Program will adopt the final MY 2026 MCAS MPL measure set upon availability by DHCS.

3. Continue to include CAHPS composites and overall ratings as member experience measures. Utilize both the child and adult CAHPS results, proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to

18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

4. Continue to use the National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles as benchmarks. For MY 2026, MY 2025 Medicaid percentiles will be used as benchmarks.

5. Maintain program funding methodology at 10% of professional capitation (base rate only).

6. Corrective Action:
HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.

7. Application of DHCS Quality Withhold:
DHCS will maintain its quality withhold and incentive program for managed care plans. For calendar year 2026, the quality withhold percent will remain 1.0% of capitation payments from each Medi-Cal managed care plan. DHCS may apply a higher withhold percentage in future Medi-Cal managed care plan contracts.

   Based on the DHCS quality measures, CalOptima Health will be assessed for the amount of withhold payments that may be earned back. The unearned percentage will be applied in CalOptima Health's P4V calculation across all HNs. Staff recommends deducting the percent of unearned DHCS withhold from each HN's earned P4V Program payment.

8. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HNs or for CalOptima Health-led initiatives such as the member health reward program, mobile or at-home health screenings, digital measure improvements, etc.

OneCare Delegated Health Network P4V Program
Staff recommends implementing MY 2026 OneCare P4V Program with the following program components:

1. Adopt the IHA pay for performance methodology, as described in the Medi-Cal section above, to assess performance. Performance will be calculated on a Star rating scale based on CMS Star ratings. The percentage of OneCare incentive earned will be determined as follows:

OneCare P4V Performance	MY2026 Incentive Percent SY2028
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%

Back to Agenda

4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY= Star rating display year

2. Utilize select CMS Part C and D measures for the P4V measurement set. Selected measures are those that are directly aligned with HN responsibilities.

3. Utilize CMS Star cut-points as benchmarks. For MY 2026, the 2028 Star Rating cut points will be used.

4. Maintain program funding at $20 per member per month (PMPM).

~~5.~~ HNs that score below the 3-Stars will be required to submit an improvement plan for that measure to CalOptima Health.

6. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HNs or for CalOptima Health-led initiatives.

Covered California Health Network P4V Program

Covered California values continuous improvement in the quality of care provided to its enrollees. To encourage quality improvement, Covered California maintains a Quality Transformation Initiative (QTI) program to provide financial incentives to Qualified Health Plans (QHP) participating in Covered California. Performance measures in QTI are based on CMS Quality Rating System (QRS) and NCQA HEDIS measures.

Staff recommends initiating a MY 2027 HN Covered California P4V Program with the following program components:

1. Adopt the Covered California QTI performance measures. For MY 2027, the calendar year 2027 QTI measures will be used.
2. Utilize NCQA Quality Compass National Exchange (NCQA Exchange) percentiles as benchmarks. For MY 2027, the MY 2026 NCQA Exchange percentiles will be used.
3. Performance will be assessed by comparing HN measure rates to the NQCA Exchange percentiles as follows:

NCQA Quality Compass National Exchange Percentile	**% of Incentive Earned per Measure**
75th	100%
66th	75%

Back to Agenda

50th	50%
33rd	25%

4. Fund the Covered California P4V Program at 10% of professional capitation (base rate only).

MY 2026 CalOptima Health Community Network Medi-Cal and OneCare Primary Care Provider P4V Programs and One-time Provider Incentives for Digital Technology Improvements

Staff recommends moving from an annual, retrospective physician pay for performance model to a real-time approach for HN and CHCN PCPs to achieve:

1. **Timely Feedback:** Real-time data will allow physicians to receive immediate feedback on their performance. This can help them quickly identify areas needing improvement and make necessary adjustments, leading to better patient outcomes and an overall improvement in CalOptima Health's quality performance.

2. **Continuous Improvement:** With real-time monitoring, physicians can continuously track their performance against quality measures. This ongoing process encourages a culture of continuous improvement rather than waiting for an annual review.

3. **Enhanced Patient Care:** Real-time data can highlight care gaps as they occur, enabling physicians to address these issues promptly. This proactive approach can lead to more timely interventions and better overall patient care.

4. **Increased Engagement:** Physicians are more likely to be engaged and motivated when they can see the immediate impact of their actions.

5. **Reduced Administrative Burden:** Annual reviews often require significant administrative work to compile and analyze data. A real-time approach can streamline this process, reducing the administrative burden on staff.

Staff recommends utilizing a software vendor to deliver the PCP P4V Program. The physician incentive software will be used by CalOptima Health contracted providers to view and close quality care gaps and earn corresponding P4V incentive dollars. The physician incentive software will:

1. Provide a single view of health-promoting behaviors and corresponding incentive values (*e.g.*, complete breast cancer screening) through a simple user interface that engages PCPs and office staff.

2. Support real-time updates to care gap closure status upon the physician/office staff taking action.

Back to Agenda

3. Ensure timely and transparent incentive payments to providers, providing payments throughout the year versus annually.

4. Support the ability to share rewards across physician office staff to engage all levels of the provider practice/clinic.

PCPs can earn incentives for implementing processes to close care gaps and for providing services to close care gaps, including the following activities:

- Calling members to schedule an appointment;
- Referring members for services such as mammograms, retinal eye exams, colonoscopy, etc.;
- Ordering laboratory tests;
- Reviewing test results with members;
- Conducting medication review; and
- Providing preventive services (*i.e.*, annual wellness visits, assessments, etc.).

Providers will have visibility to their member panel with care gaps, actions that can earn incentives, and their progress made toward earning incentives as actions are taken and care gaps are closed. Incentives will range from $5 to $50 depending on the action taken and care gap closed.

One-time Provider Incentives for Digital Technology Improvements: This program will also include one-time incentives of $1,000 per type per provider for adopting the following digital technology improvements:

- Conversion from paper checks to electronic fund transfer.
- Provider portal adoption.
- Provider electronic medical record adoption.

Staff will initiate the PCP P4V Program with OneCare and add Medi-Cal after an initial pilot period during Quarter 1 of 2026. Funding for this program and the one-time incentives to support provider adoption of digital technology improvements will draw from MY 2024 unearned P4V funds.

MY 2026 Unearned Incentive Dollars

MY 2026 P4V funds that remain unused – due to HNs failing to earn the maximum incentive possible or due to forfeitures based on CalOptima Health's failure to achieve the MPL – may be used for quality improvement initiatives. Grants will be available from unearned funds for both Medi-Cal and OneCare.

HNs may apply for grants to utilize incentive dollars for quality improvement initiatives. Grants may be awarded for individual measures or groups of measures targeting similar member populations, for example, well-child visits and childhood immunizations. Total grant funds to an individual HN will not exceed the HN's maximum pool funding incentive for each MY, including deduction for DHCS

Back to Agenda

quality withholds. Grants may not be used to fund administrative staffing nor for capital investments but may be used for staff for direct implementation of quality initiatives.

Staff will provide oversight of grants pursuant to CalOptima Health Policy AA.1400: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings.

CalOptima Health will utilize a portion of the unearned HN P4V funds for the MY 2026 PCP P4V programs and for CalOptima Heath quality improvement initiatives such as member outreach and education, programs to close care gaps, and programs to close data gaps.

Unearned incentive funds will be used as described herein. Staff will finalize expenditures from the MY 2026 P4V programs by Quarter 4 of 2028 and report back to the Board of Directors.

Eligibility for Incentive Payments
Performance incentive payments are distributed upon final calculation and validation of each measurement rate. To qualify for payments, a HN must be contracted with CalOptima Health during the entire measurement period (January 1, 2026, through December 31, 2026), the calculation period (January 1, 2027, through December 30, 2027), and at the time of disbursement of payment. HNs and PCPs must also be in good standing with CalOptima Health at the time of disbursement of payment. Good standing includes the provider having an active contract, including contract amendments; being free of contract sanctions and limitations; and not having substantive corrective action, as determined by the Audit and Oversight department. HNs must distribute a minimum of 85% of their incentive payment to their contracted physicians.

Fiscal Impact

Medi-Cal P4V Program
Staff estimates that the fiscal impact for the MY 2026 P4V Program will be no more than 10% of the professional capitation (base rate only) or approximately $73.9 million. Staff will include estimated pool funding for the MY 2026 P4V Program initiatives and grant activities in the Fiscal Year (FY) 2026-27 Operating Budget.

OneCare P4V Program
Staff estimates that the fiscal impact for the MY 2026 OneCare P4V Program will be no more than $20 PMPM or approximately $4.3 million. Staff will include estimated pool funding for the MY 2026 P4V Program initiatives and grant activities in the FY 2026-27 Operating Budget.

Back to Agenda

Covered California P4V Program
Staff estimates that the fiscal impact for the MY 2027 Covered California P4V Program will be no more than 10% of the final professional capitation. Staff will include estimated pool funding for the MY 2027 Covered California P4V Program initiatives in future operating budgets.

MY2026 CalOptima Health Community Network Medi-Cal and OneCare PCP P4V Programs and One-time Provider Incentives for Digital Technology Improvements
Staff estimates that the fiscal impact for the MY 2026 Medi-Cal PCP P4V Program will not exceed $10.0 million, and the OneCare PCP P4V Program will not exceed $1.0 million. The fiscal impact for the one-time incentives to support provider adoption of digital technology improvements is estimated at $6.0 million for Medi-Cal and $1.0 million for OneCare. Staff anticipates that the estimated remaining balances in unearned funds from the MY 2024 Medi-Cal and OneCare P4V Programs will be sufficient to fund these initiatives.

Rationale for Recommendation
CalOptima Health strives to continuously improve the quality of care and outcomes for all members. CalOptima Health is committed to demonstrating breakthrough improvement in quality measures, achieving high performing managed care plan status and achieving a 5-Star rating status. To achieve optimal quality performance and more fully engage the physician network, it is critical that CalOptima Health shift from a retrospective P4V model to a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Measurement Year 2026 Pay for Value Programs
2. Measurement Year 2026 Pay for Value Programs and Measurement Year 2027 Covered California Pay for Value Program Presentation

/s/ Michael Hunn *11/07/2025*
Authorized Signature **Date**

Back to Agenda

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs and MY 2027 Covered California Pay for Value Program

MY 2026 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also includes incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health primary care providers are eligible to participate in the Medi-Cal P4V program.

MY 2026 Medi-Cal P4V Program Components

1. Include measures held to a DHCS MPL or quality withhold in the MY2026 MCAS measure set.

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

- Utilize both Child and Adult CAHPS scores proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement scores are calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points

Back to Agenda Back to Item

- Scale of 1-10 points
- Points based on performance between 50th percentile and 95th percentile.
- $1 + \left(\frac{(MY2026\ Rate - 50th\ Percentile)}{((95th\ Percentile - 50th\ Percentile)/9)} \right)$

▪ Improvement Points
- Scale of 0-10 points
- Points reflect performance in the prior year compared to the current year.
- $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((95th\ Percentile - MY2025\ Rate)/10)} \right)$

3. Prior year (MY2025) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks. *Developmental Screening in the First Three Years of Life and Topical Fluoride are CMS measures where the only benchmark is the 50th percentile. For these two measures, CMS percentiles will be used and HNs will earn 10 points for performance at or above the 50th percentile and 1 point for performance below the 50th percentile.
4. Measure weighting
   - HEDIS measures weighted 1.0
   - CAHPS measures weighted 1.5
5. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
6. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance.
7. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.
8. DHCS quality withhold penalties will be deducted from each HN's earned P4V program payment.

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs and MY 2027 Covered California Pay for Value Program

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

MY 2026 OneCare P4V Program Components

Alignment with the CMS Star program and the following components- CMS Star Part C and Part D measures, measure weights, and Star cut points as benchmarks:

1. Utilize a subset of CMS Star measures

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	**Measure**
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Care for Older Adults- Medication Review
	Care for Older Adults- Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Statin Therapy for Patients with Cardiovascular Disease
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Network Quality
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

   - Scoring

Back to Agenda Back to Item

- Attainment Points
  - Scale of 1-5 points
  - Points based on performance between 3-Star and 5-Star cut points.
  - $1 + \left(\frac{(MY2026\ Rate - 3\ Star\ cut\ point)}{((5\ Star\ cut\ point - 3\ Star\ cut\ point)/4)} \right)$
- Improvement Points
  - Scale of 0-5 points
  - Points reflect performance in the prior year compared to the current year.
  - $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((5\ Star\ cut\ point - MY2025\ Rate)/5)} \right)$

3. MY2026 CMS Star cut points used as benchmarks. These benchmarks will be released by CMS in Q4 2027 in the 2028 Star Rating Technical Notes.
4. Measure weighting
   - HEDIS process measures weighted 1
   - CAHPS measures weighted 2
   - Outcome measures weighted 3
5. Apply a program funding methodology of $20 PMPM
6. Available Incentive Pool: the OneCare incentive pool will be determined by each HN's Stars performance as described in the table below. Actual OneCareP4V incentives will be based on performance as described in this section.

OneCare P4V Performance	MY2026 Incentive Percentage **SY2028**
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY= Star rating display year

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance
8. HNs that score below 3.0 Stars will be required to submit an improvement plan for that measure to CalOptima Health.

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs and MY 2027 Covered California Pay for Value Program

Covered California Pay for Value Program (P4V)

The Covered California P4V program focuses on measures included in the Quality Transformation Initiative. Health networks (HNs) are eligible to participate in the Covered CA P4V program.

MY 2027 Covered CA P4V Program Components

Alignment with the Covered CA Quality Transformation Initiative (QTI) and the following components:

1. CalOptima Health will adopt the 2027 QTI measures for the MY2027 P4V Program.

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

2. Utilize an attainment scoring methodology where rates that meet designated benchmarks qualify for percentages of incentives per measure
3. MY2026 National Committee for Quality Assurance (NCQA) Quality Compass National Exchange percentiles used as benchmarks
4. Measures will be weighted equally
5. Establish program funding at ten percent (10%) of professional capitation (base rate only)
6. Covered CA P4V incentives will be based on performance compared to benchmarks as described below:

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance

Measurement Year (MY) 2026 Pay for Value Program

Special Quality Assurance Committee Meeting

November 13, 2025

Linda Lee, Executive Director Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Background

- CalOptima Health has implemented a Pay for Value Program (P4V) to reward high performing Health Networks
- CalOptima Health's P4V program has historically provided upside incentives and no downside penalties
- The P4V program has resulted in mixed performance across products and at the Health Network level

MY2026 Delegated Health Network P4V Program Components

MY2026 P4V Program Elements

- Measure Sets
  - Medi-Cal: Align with DHCS MCAS MPL and Quality Withhold measures
    - Utilize HEDIS and DHCS clinical measures
    - Utilize both Child and Adult CAHPS rates
  - OneCare: Align with CMS Star measures most impactable by HNs
    - Utilize Part C HEDIS and CAHPS measures
    - Utilize Part D measures

MY2026 P4V Program Elements

- Measure Weights
  - Align with industry measure weights, where applicable
  - Clinical measures = 1.0
  - Medi-Cal Member experience measures = 1.5
  - OneCare Member experience measures = 2.0
- Data Collection Methodology
  - To promote adoption of electronic clinical data sets, utilize administrative data

Performance Methodology and Benchmarks

- Adopt Integrated Healthcare Association (IHA) scoring method
  1. Performance points are calculated by comparing HN score to benchmarks, starting at the 50th percentile for Medi-Cal and 3-Stars for OneCare
  2. Performance points are also calculated by comparing a HN's prior year score to current score
- Use option 1 or 2, selecting option with higher number of points
- Medi-Cal
  - Based on NCQA National Medicaid Percentiles
- OneCare
  - Based on CMS Star cut points

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Medi-Cal P4V Incentive Percentages

- A total quality score is calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum.
- The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned.
  - For example, a quality rating of 3.5 equates to 35% of the incentive allocation

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OneCare P4V Incentive Percentages

OneCare P4V Performance	MY2026 Incentive Percent SY2028
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Health Network Corrective Action

- Corrective action: HN scoring below the MPL on Medi-Cal or below 3.0 Stars on Medicare must submit a corrective action plan

Additional Health Network Penalties

- CalOptima Health will pass down any impact of the DHCS quality withhold program
  - For MY2026, the withhold is 1.0% of capitation
  - Any unearned withhold will be deducted from each HN's PV4 program payment

MY2026 Incentive Pool

- Medi-Cal:
  - Ten percent of professional capitation (base rate only)
  - Estimated at $73 million

- OneCare:
  - $20pmpm
  - Estimated at $4.3 million

Unearned Incentive Dollars

- Issue quality grants using unearned dollars
- Grants will be used to improve individual or groups of measures
- Funds used for quality improvement efforts including staff directly involved with quality initiatives
- HNs submit a plan, subject to quarterly monitoring
  - Must meet implementation requirements to continue to access improvement funds
- CalOptima Health will implement delivery system-wide interventions

MY2027 Covered CA P4V Program

MY2027 Covered CA Program Components

- Utilized Covered CA Quality Transformation Initiative (QTI) measure set
- Measures will be equally weighted
- Utilize NCQA Exchange National Percentiles as benchmarks
- Performance assessed on attainment of benchmarks
  - P4V program budgeted at ten percent of professional capitation (base rate only)

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MY2027 Covered CA P4V Incentive Percentages

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

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MY2026 Primary Care Provider P4V Program Components

Primary Care Provider P4V

- Carve-out a portion of Health Network P4V for primary care provider (PCP) incentives from unearned incentives to drive improvement at the point of care
- CalOptima Health issued an RFP in August 2025 to acquire a vendor to implement this program
- PCPs can earn incentives for implementing processes to close care gaps and for providing services to close care gaps
  - Call members to schedule an appointment
  - Refer members for services
  - Review results with members
  - Provide services i.e. annual wellness visits, assessments, etc.

One-Time Provider Incentives for Digital Technology Improvements

- Conversion from paper checks to electronic fund transfer
  - One-time incentive of $1000 per provider
- Provider Portal adoption
  - One-time incentive of $1000 per provider
- Provider EMR adoption
  - One-time incentive of $1000 per provider

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CalOptima Health Investments

- CalOptima Health is in the process of implementing Cozeva PayerOne
  - Direct access to provider EMR
  - Provides a data system for providers to update care gap closure
  - Provides a data system for providers to submit supplemental data

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APPENDIX

MY2026 Medi-Cal P4V Measurement Set

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening

MY2026 Medi-Cal P4V Measurement Set

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

MY2026 OneCare P4V Measurement Set

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	Measure
Part C	Breast Cancer Screening
HEDIS	Colorectal Cancer Screening
	Care for Older Adults- Medication Review
	Care for Older Adults- Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Statin Therapy for Patients with Cardiovascular Disease

MY2026 OneCare P4V Measurement Set

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	Measure
Part C	Care Coordination
Member Experience	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Network Quality
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

MY2027 Covered CA P4V Measurement Set

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

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OneCare Stars Update

Special Quality Assurance Committee Meeting

November 13, 2025

Linda Lee, Executive Director Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Back to Agenda

Trended OneCare Star Performance

Star Year	2022	2023	2024	2025	2026
Measurement Year	2020	2021	2022	2023	2024
Overall Star Rating	4	3	3	2.5	3
Part C	3.5	2.5	3	3	2.5
Part D	4.5	3.5	3.5	3	3

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Back to Agenda

Measures that Significantly Improved (SR 2026)

Measure	Status
C01: Breast Cancer Screening	Significant improvement
C03: Annual Flu Vaccine	Significant improvement
C07: Special Needs Plan (SNP) Care Management	Significant improvement
C10: Osteoporosis Management in Women who had a Fracture	Significant improvement
C14: Controlling High Blood Pressure	Significant improvement
C21: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Significant improvement
C26: Rating of Health Plan	Significant improvement

Measures that Significantly Declined (SR 2026)

Measure	Status
C08: Care for Older Adults - Medication Review	Significant decline
C09: Care for Older Adults - Pain Assessment	Significant decline
C17: Medication Reconciliation Post-Discharge	Significant decline
C20: Transitions of Care	Significant decline
C32: Reviewing Appeals Decisions	Significant decline

Measures with No Significant Change (SR 2026)

Measure	Status
C02: Colorectal Cancer Screening	No significant change
C06: Monitoring Physical Activity	No significant change
C11: Diabetes Care - Eye Exam	No significant change
C12: Diabetes Care - Blood Sugar Controlled	No significant change
C15: Reducing the Risk of Falling	No significant change
C16: Improving Bladder Control	No significant change
C18: Plan All-Cause Readmissions	No significant change
C19: Statin Therapy for Patients with Cardiovascular Disease	No significant change
C22: Getting Needed Care	No significant change
C23: Getting Appointments and Care Quickly	No significant change
C24: Customer Service	No significant change
C25: Rating of Health Care Quality	No significant change
C27: Care Coordination	No significant change
C29: Members Choosing to Leave the Plan	No significant change
C31: Plan Makes Timely Decisions about Appeals	No significant change
C33: Call Center - Foreign Language Interpreter and TTY Availability	No significant change

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Back to Agenda

Quality Improvement Priorities

Back to Agenda

Member Focus: Close Care Gaps

- Deploy at-home visit vendor to impact:
  - Care for older adults, transitions of care, and screening measures
- Widen at-home lab testing to include HbA1c screening and Kidney Health evaluation for patients with diabetes
- Send out Cologuard tests
- Direct schedule CHCN members due for mammography
- Continue live outreach calls to schedule PCP visits

Provider Focus: Close Care Gaps

- Send focused care gap lists to top 25 PCPs
- Send focused care gap lists to Health Networks
- GI specialty collaboration for colorectal cancer screening
- Deploy mobile mammography to high-volume OneCare practices

Data Focus: Capture Evidence of Services Provided

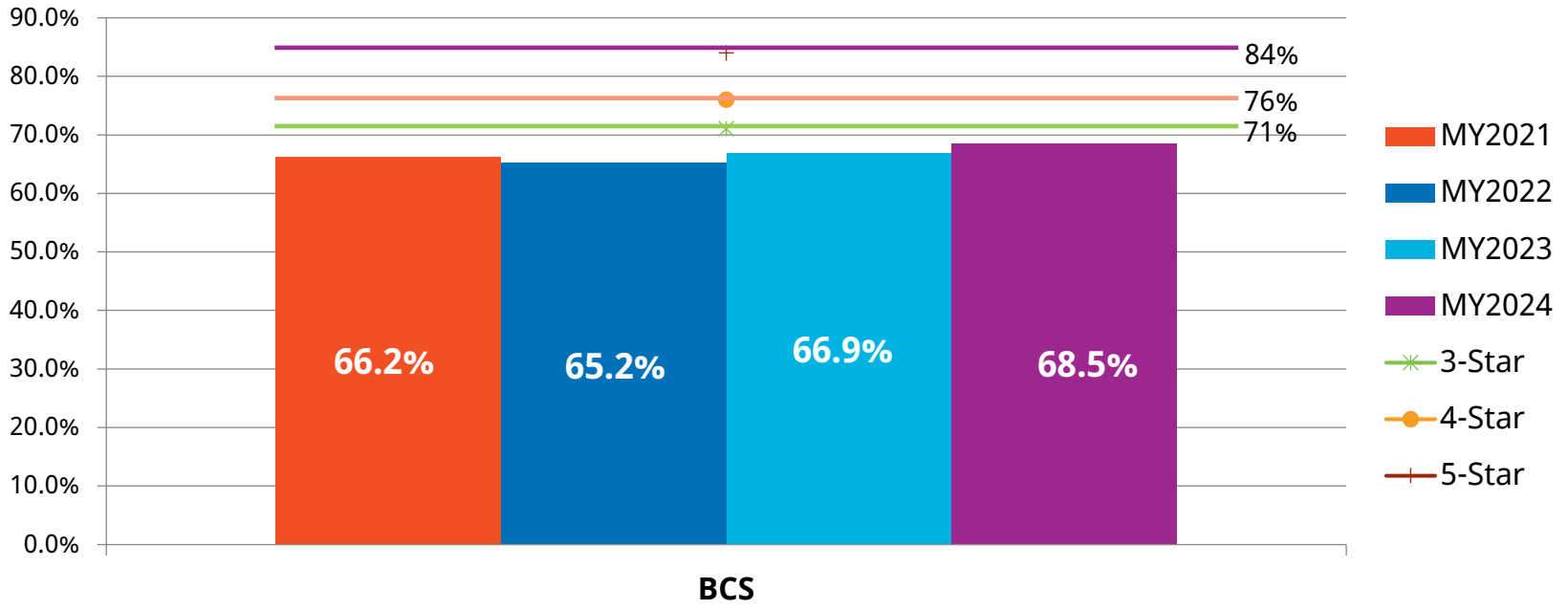
- Launch Cozeva Payer One to establish data exchange with Health Networks
- Obtain historical lab results from lab vendors
- Expand CHCN medical record review to include:
  - Breast cancer screening
  - Colorectal cancer screening
  - Eye exams for patients with diabetes
  - Osteoporosis management

APPENDIX

Back to Agenda

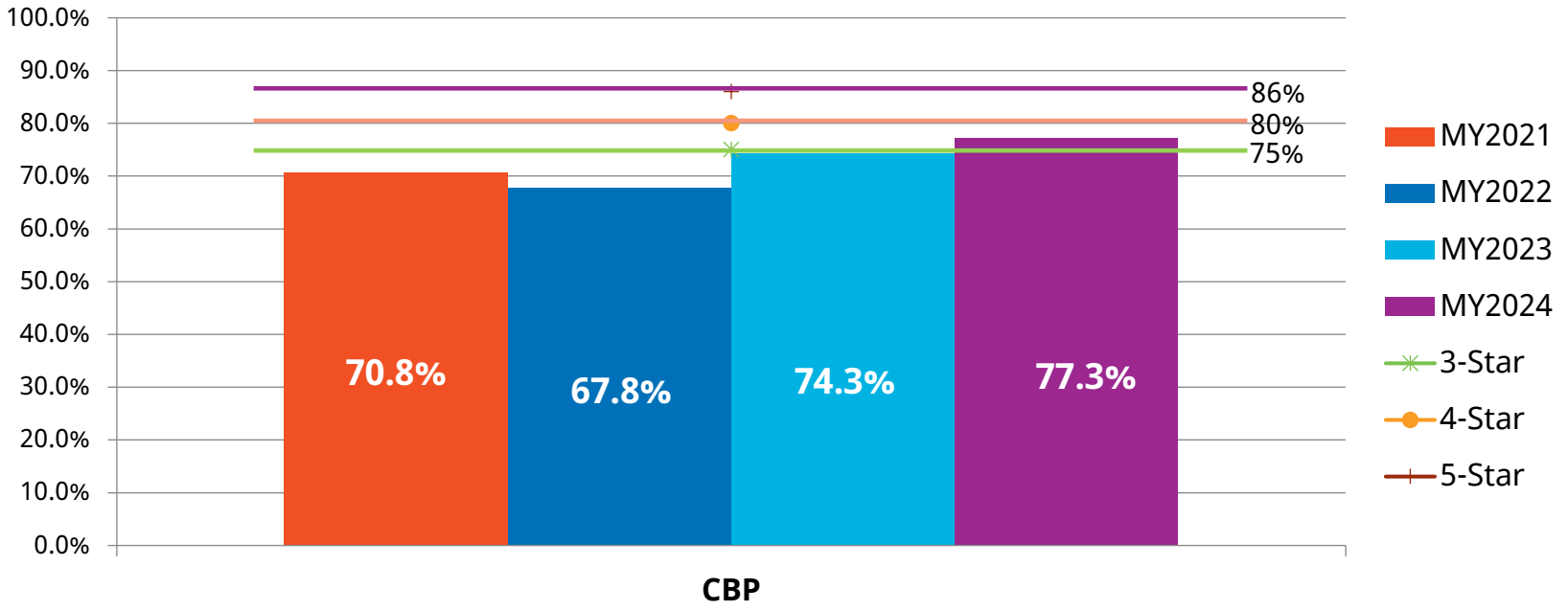
HEDIS MY2024 Results: Medicare

Breast Cancer Screening (BCS)



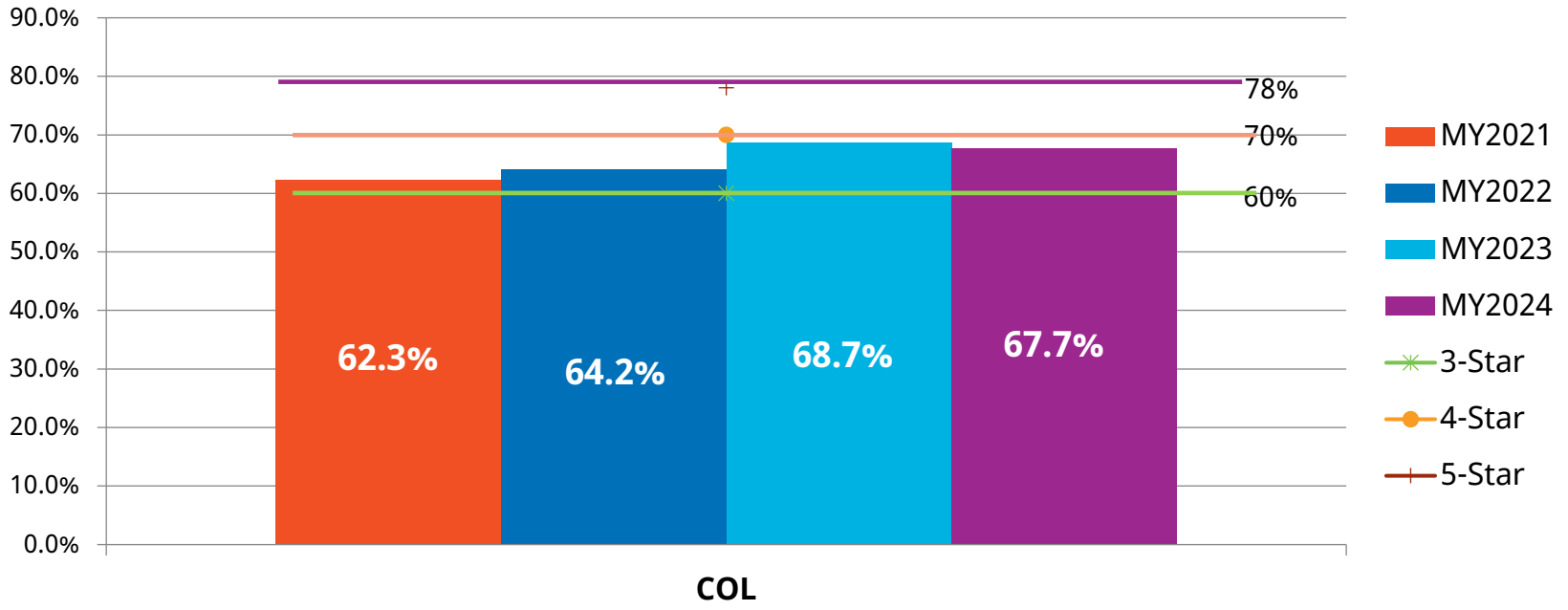
HEDIS MY2024 Results: Medicare

Control High Blood Pressure (CBP)



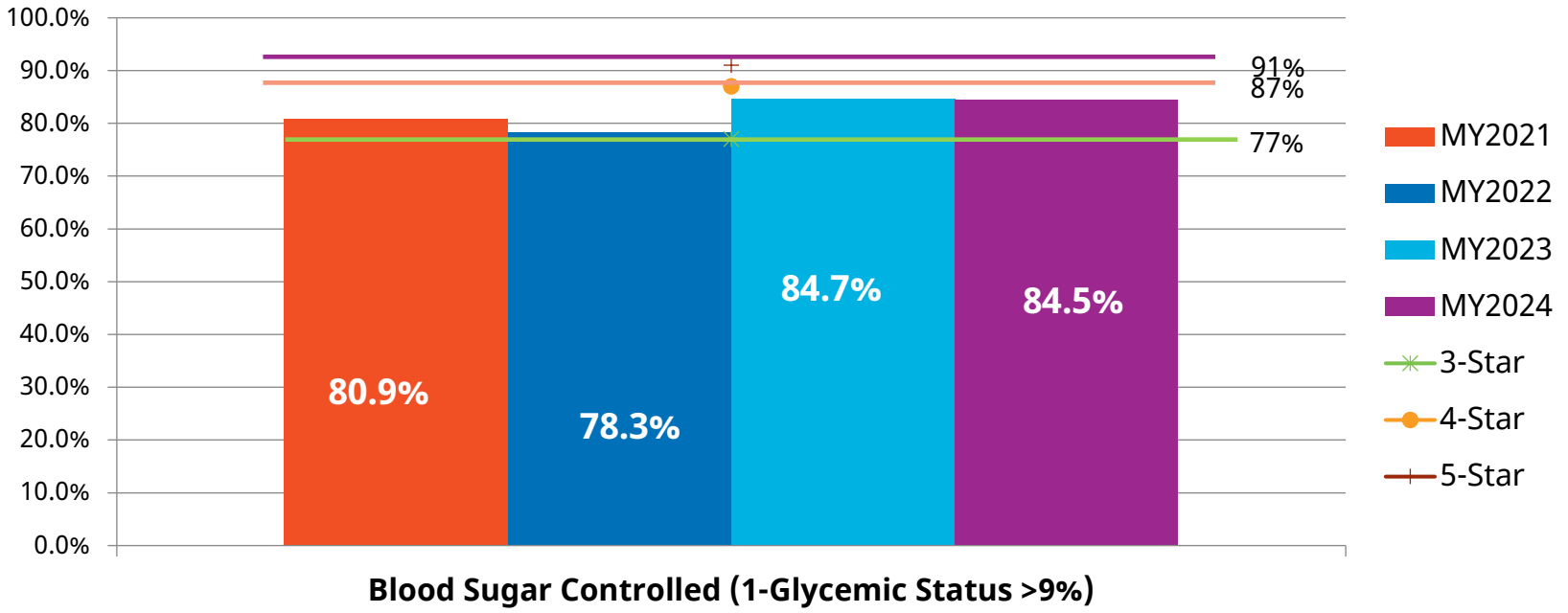
HEDIS MY2024 Results: Medicare

Colorectal Cancer Screening (COL)



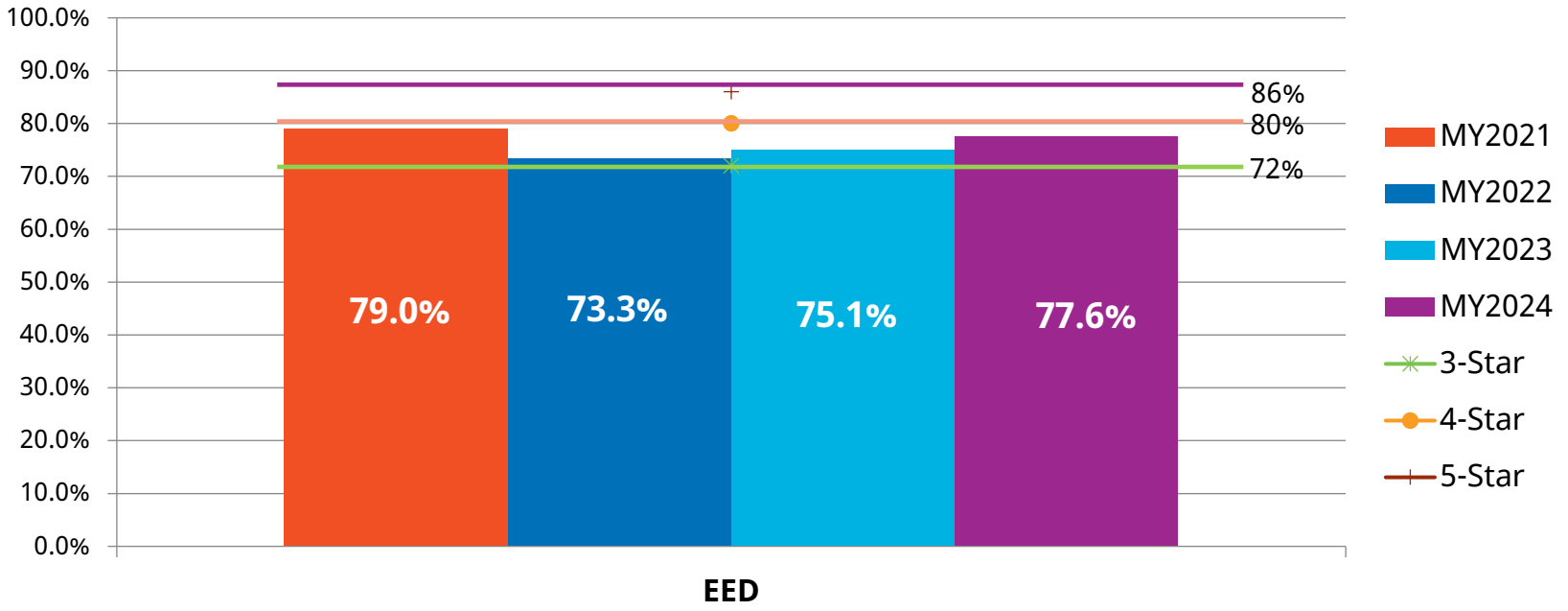
HEDIS MY2024 Results: Medicare

Glycemic Status Assessment for patients with Diabetes (GSD)



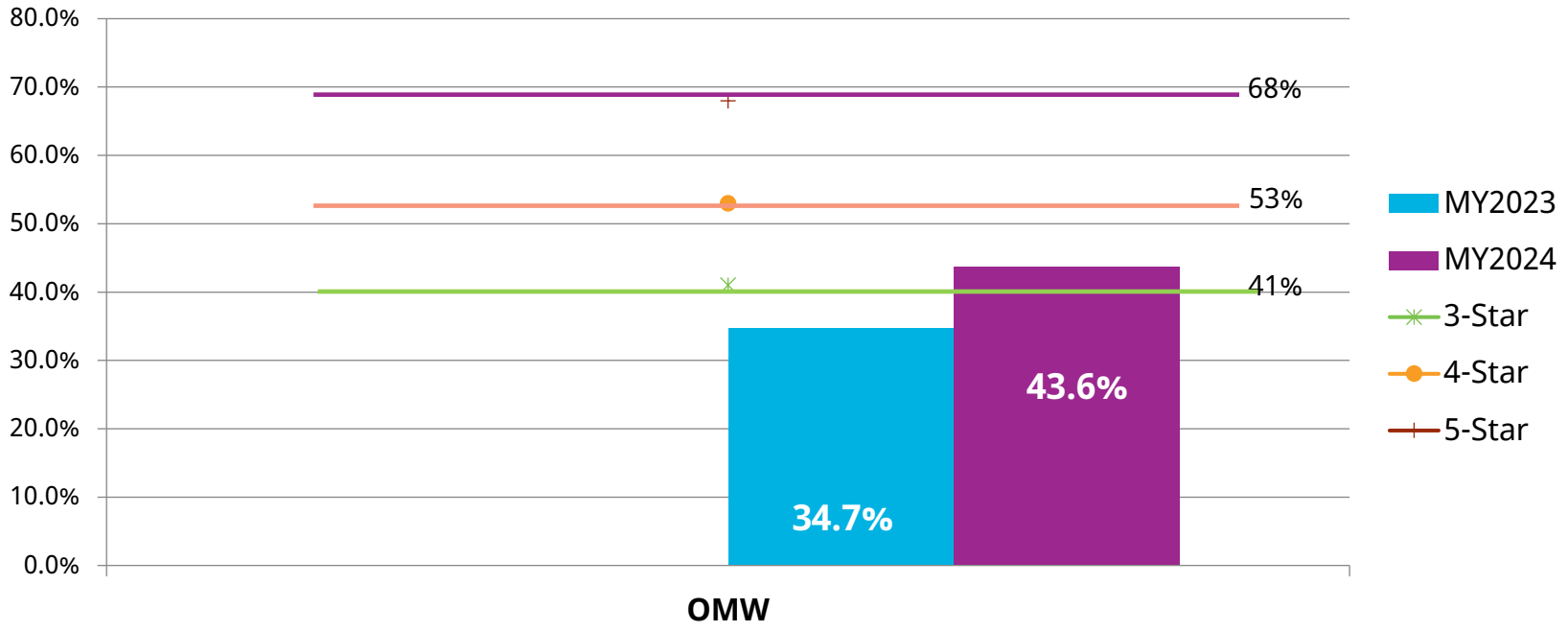
HEDIS MY2023 Results: Medicare

Eye Exams for Patients with Diabetes (EED)



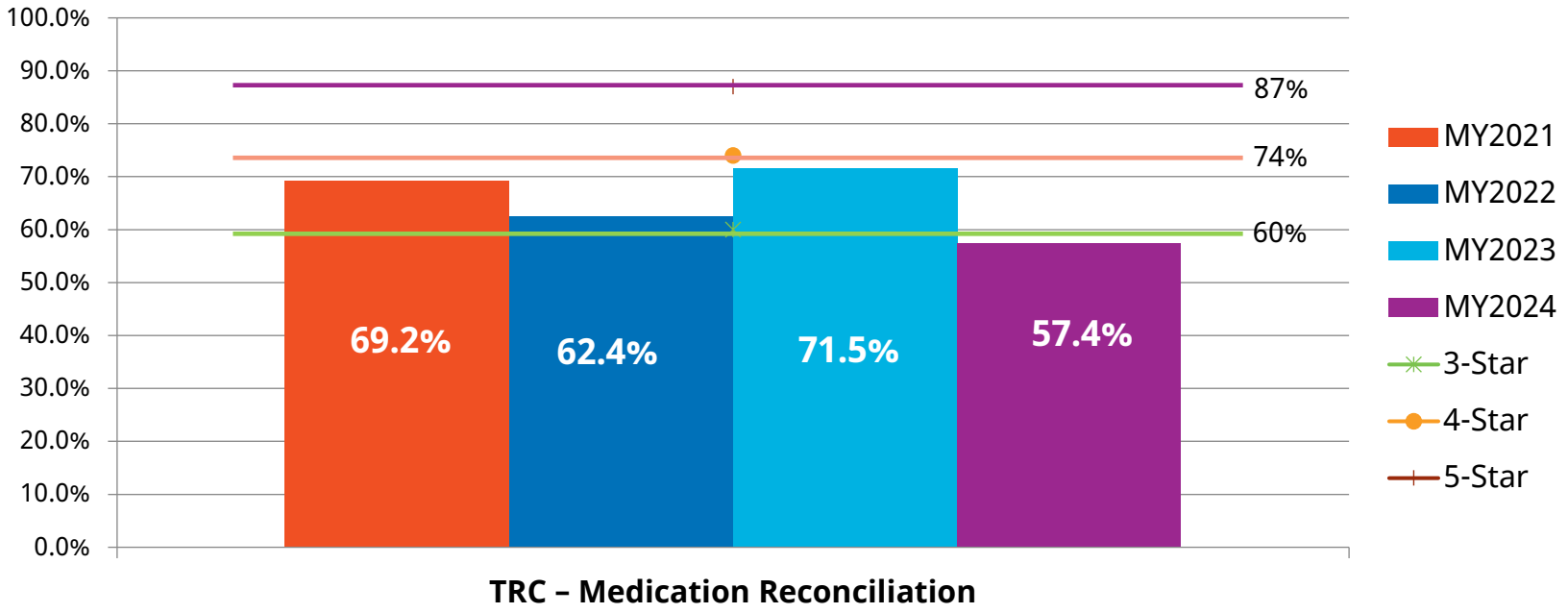
HEDIS MY2024 Results: Medicare

Osteoporosis Management in Women with a fracture (OMW)



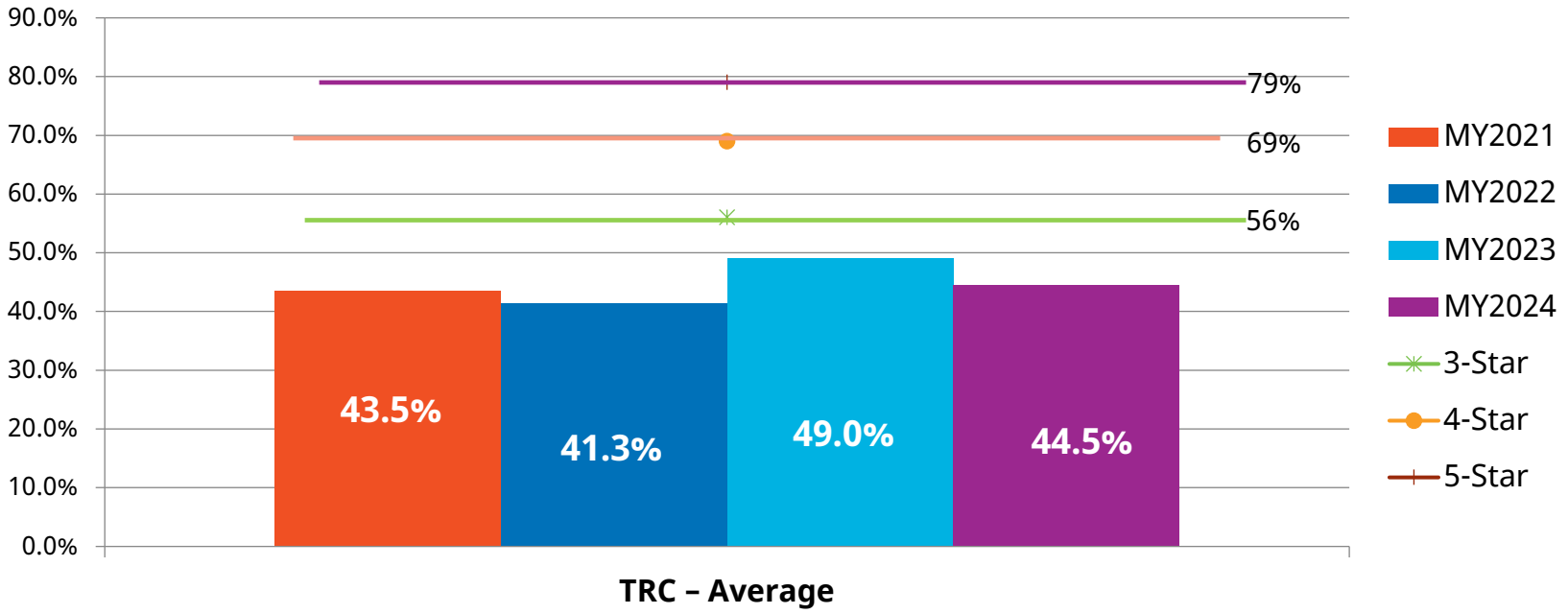
HEDIS MY2024 Results: Medicare

Transition of Care (TRC)– Medication Reconciliation



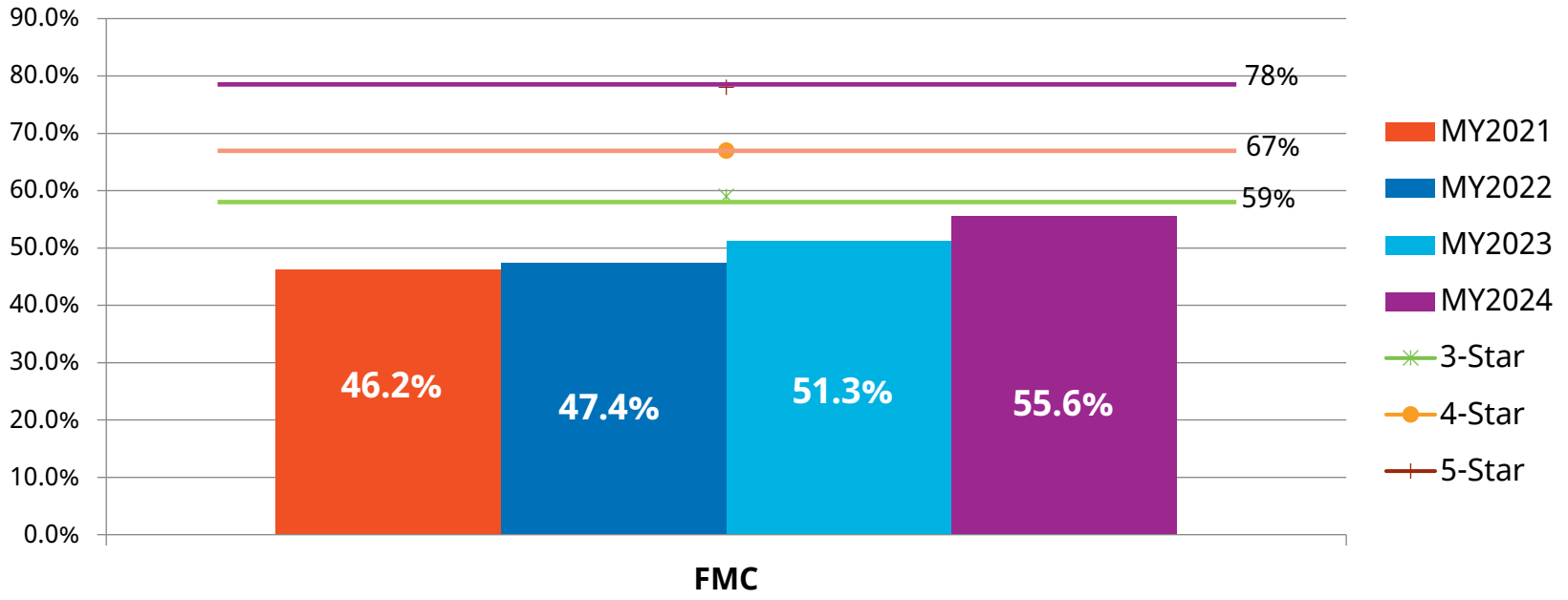
HEDIS MY2024 Results: Medicare

Transition of Care (TRC) - Average



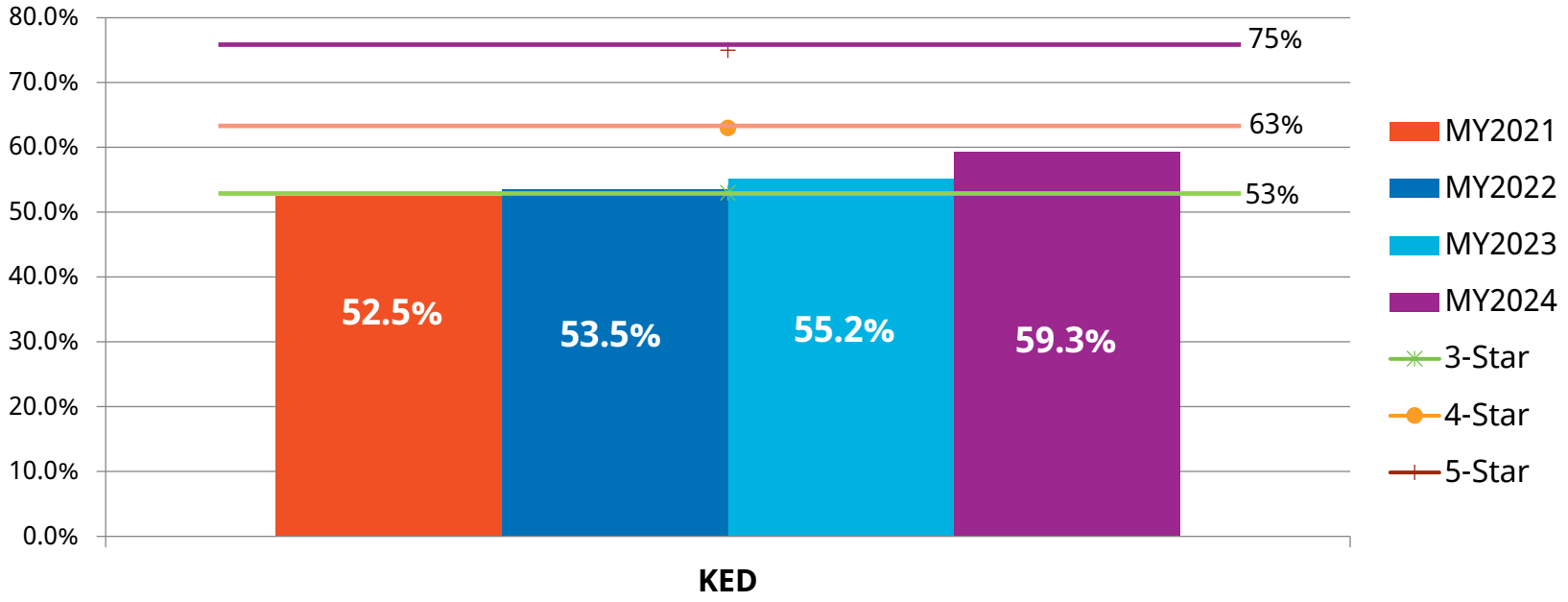
HEDIS MY2024 Results: Medicare

Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)



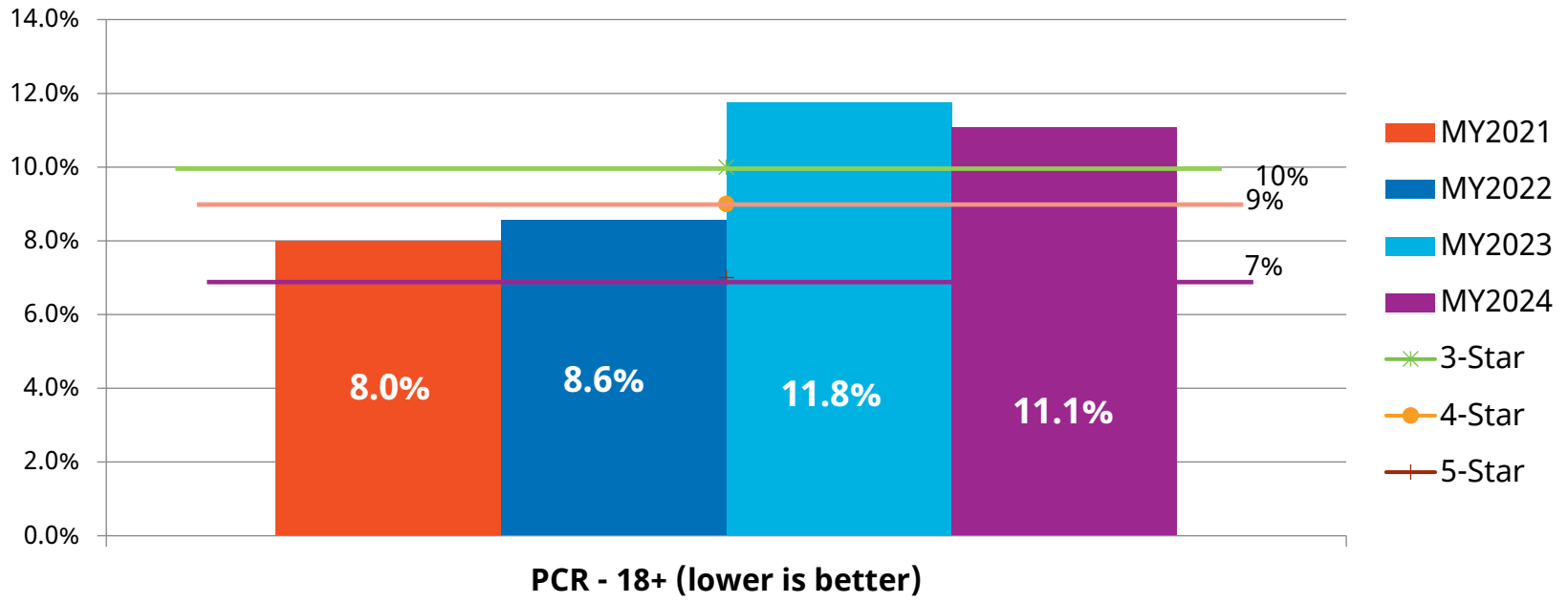
HEDIS MY2024 Results: Medicare

kidney Health Evaluation for Patients with Diabetes (KED)



HEDIS MY2024 Results: Medicare

Plan All-Cause Readmissions (PCR) – 18+



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